

INDIVIDUALIZED HEALTHCARE PLAN – DIABETES WITH INJECTION

HEALTHCARE PROVIDER ORDERS

EFFECTIVE DATE:		End Date:	
STUDENT'S NAME:		Date of Birth:	
DIABETES HEALTHCARE PROVIDER INFORMATION			
Phone #:		Fax #:	
Name:		Email:	
SCHOOL INFORMATION:		School Nurse:	
Name:		Name:	
School Fax:		Phone:	

STUDENTS WITH DIABETES TREATED BY INJECTION

Monitor Blood Glucose – test ...

☒ If student has symptoms of high or, **without moving student**, low blood glucose

☐ Before breakfast
☐ Before mid-morning snack
☐ Before lunch

☐ After lunch
☐ Before afternoon snack
☐ Before leaving school

☐ Before exercise/PE
☐ After exercise/PE
☐ Other:

Where to test: ☐ Classroom ☐ Health office ☐ Other: _____

☒ **Without moving student if has low blood glucose symptoms**

Routine Daily Insulin Injection:

Insulin Delivery: ☐ Syringe/vial ☐ Pen

Type: ☐ rapid acting (Humalog / NovoLog / Apidra) ☐ regular or ☐ other: _____

☐ Calculate insulin dose for carbohydrate intake:

Give _____ unit(s) of rapid-acting insulin for _____ grams of carbohydrate.

Give at: ☐ breakfast ☐ AM snack
☐ lunch ☐ PM snack ☐ parties.

OR

☐ Standard daily insulin injection:

Type	Dose	Time

Correction insulin dose for high blood glucose:

Time to be given: ☐ Before lunch **ONLY** ☐ Other: _____

☐ Use correction scale

Blood glucose range	Insulin units

☐ Use Formula to calculate correction dose

(Blood glucose- _____ ÷ _____) = _____ units of insulin.

☐ Carbohydrate coverage and pre-meal correction doses may be combined.

Do not give insulin correction dose more than once every 2 to 3 hours.

Check ketones if nausea, vomiting or abdominal pain OR if blood glucose >300 twice when tested 3 hours apart.

- Give _____ units of rapid-acting insulin for moderate and _____ units for large ketones.
- Repeat ketone test in 2 hours, and repeat additional insulin if moderate or large ketones are still present.

Exercise and Sports ☐ Student should monitor blood glucose hourly.

Parent/Guardian Authority to Adjust Insulin Dose

☐ Increase or decrease correction scale ☐ +/-10%

☐ +/-20%

☐ Increase or decrease insulin-to-carbohydrate ratio

☐ +/-10% ☐ +/-20%

Other Health Concerns and Medications

Other health concerns: _____ Allergies: _____

☐ Glucagon Dose: _____ IM or SC per thigh or arm

☐ Oral diabetes medication(s)/dose: _____ Times to be given: _____

☐ Other medication(s)/dose: _____ Times to be given: _____

☐ _____ Times to be given: _____

HCP Assessment of Student's Diabetes Management Skills:

Skill	Independent	Needs supervision	Cannot do
Check blood glucose			
Count carbohydrates			
Calculate insulin dose			
Injection			

Note: _____

HEALTHCARE PROVIDER

SIGNATURE/STAMP:

Date:

INDIVIDUALIZED HEALTHCARE PLAN – DIABETES WITH PUMP

HEALTHCARE PROVIDER ORDERS

EFFECTIVE DATE:		End Date:	
STUDENT'S NAME:		Date of Birth:	
DIABETES HEALTHCARE PROVIDER INFORMATION		Name:	
Phone #:	Fax #:	Email	
SCHOOL INFORMATION:		School Nurse:	
Name:		Name:	
School Fax:		Phone:	

Monitor Blood Glucose – test ...

☒ If student has symptoms of high or low blood glucose
☐ Before breakfast
☐ Before mid-morning snack
☐ Before lunch
☐ All test results should be entered into pump to determine need for bolus correction.

☐ After lunch
☐ Before afternoon snack
☐ Before leaving school

☐ Before exercise/PE
☐ After exercise/PE
☐ Other:

Where to test: ☐ Classroom ☐ Health office ☐ Other: _____

☒ **Without moving student if has low blood glucose symptoms**

Insulin Pump Information ☐ Humalog or NovoLog or Apidra by pump

Basal rates during school: _____

☐ Place pump on suspend when blood glucose is less than _____ mg/dl and re-activate it when blood glucose is at least _____ mg/dl.

Pump settings should not be changed by school staff.

Carbohydrate Bolus

Give 1 unit of insulin per	Time
gm carbohydrate at breakfast	
gm carbohydrate at AM snack	
gm carbohydrate at lunch	
gm carbohydrate at PM snack	

Bolus should occur: ☐ before eating, or ☐ other: _____

Correction Bolus for Hyperglycemia

- Give _____ units of insulin for each _____ mg/dl of blood glucose with a target blood glucose of _____ mg/dl.
- Check ketones** if nausea, vomiting or abdominal pain OR if blood glucose >300 twice when tested 3 hours apart.
 - Via syringe**, give _____ units for moderate and _____ units of rapid-acting insulin for large ketones. Repeat blood glucose test in 2 hours, and repeat additional insulin if moderate or large ketones are still present.

Do not give correction dose of insulin more than once every 2 to 3 hours.

If infusion set comes out or needs to be changed: ☐ Change set at school ☐ Insulin via syringe every 3 hours

Exercise and Sports with Pump

Temporary Basal Decrease: ☐ No ☐ Yes (____% or _____ units for _____ minutes or ☐ duration of exercise)

☒ Student should monitor blood glucose hourly.

HCP Assessment of Student's Diabetes Management Skills:

Skill	Independent	Needs supervision	Cannot do	Notes:
Check blood glucose				
Count carbohydrates				
Calculate insulin dose				
Change infusion set				
Injection				
Trouble shoot alarms, malfunctions				

Parent/Guardian Authority to Adjust Insulin Dose

☐ Increase or decrease correction

☐ +/-10%

☐ +/-20%

☐ Increase or decrease insulin-to-carbohydrate ratio

☐ +/-10%

☐ +/-20%

Other Medications and Health Concerns

Other health concerns: _____ Allergies: _____

☐ Glucagon Dose: _____ IM or SC per thigh or arm

☐ Oral diabetes medication(s)/dose: _____ Times to be given: _____

☐ Other medication(s)/dose: _____

☐ Times to be given: _____

HEALTHCARE PROVIDER SIGNATURE/STAMP:	Date:
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STUDENTS WITH DIABETES TREATED BY PUMP

STUDENT'S NAME:

Student's usual LOW blood glucose symptoms:

- _ Shaky or jittery
- _ Sweaty
- _ Hungry
- _ Pale
- _ Headache
- _ Blurry vision
- _ Sleepy
- _ Dizzy
- _ Uncoordinated
- _ Irritable, nervous
- _ Argumentative
- _ Combative
- _ Changed personality
- _ Changed behavior
- _ Unable to concentrate
- _ Weak, lethargic

ALGORITHMS FOR BLOOD GLUCOSE RESULTS

CHECK BLOOD GLUCOSE

Student's usual HIGH blood glucose symptoms:

Hyperglycemia

- _ Increased thirst, dry mouth
- _ Frequent or increased urination
- _ Change in appetite, nausea
- _ Blurry vision
- _ Fatigue
- _ Other

Emergency levels

- _ Extreme thirst
- _ Nausea, vomiting
- _ Severe abdominal pain
- _ Fruity breath
- _ Heavy breathing, shortness of breath
- _ Increasing sleepiness, lethargy

BELOW 70

70 – 90

91-125

126-300

ABOVE 300

1. Give 15 gm fast-acting carbohydrate
2. Observe for 15 minutes
3. Retest blood glucose.
 - a. If less than 70, repeat 15 gm carbohydrate.
 - b. If over 70, give carbohydrate and protein snack (e.g., crackers and cheese) if not eating a meal within an hour.
4. Notify school nurse and parent if no improvement
5. Student should not exercise

1. Give 15 gm fast-acting carbohydrate.
 - a. If meal or snack is within 30 minutes, no additional carbs are needed.
 - b. If student is not going to eat within 30 minutes, give carbohydrate and protein snack.

If student's blood glucose result is immediately following strenuous activity, give 15 gm carbohydrate snack.

Student may eat before exercising or recess.

No action needed.

STUDENT TREATED BY INJECTION

1. Use correction scale or formula at lunch or every 2-3 hours
2. Check ketones if symptoms or if blood glucose > 300 twice in a row:
 - a. If ketones are absent or small, encourage exercise and water
 - b. If ketones moderate or large:
 - No exercise; give water
 - Add units of insulin per orders
3. Notify school nurse and parent
4. **Provide free, unrestricted access to water and the restroom.**

STUDENT TREATED BY PUMP

1. If 2-3 hours since last bolus, treat with correction bolus via pump. Re-check in 2-3 hrs. Troubleshoot pump function.
 - Check for redness at site, tubing for kinks or air bubble, insulin supply
2. If blood glucose still ≥ 300 mg/dl and not explained, check ketones:
 - a. If ketones are absent or small, encourage exercise and water
 - b. If ketones moderate or large:
 - Give insulin correction dose per orders **via syringe**.
 - No exercise; encourage water
3. Change infusion set or continue insulin injections every 2-3 hours via syringe.
4. Notify school nurse and parent
5. **Provide free, unrestricted access to water and the restroom.**

CALL 911 if the student vomits, becomes lethargic and/or has labored breathing. Notify school nurse, parent and HCP.

CALL 911 if student becomes unconscious, seizures or is unable to swallow

- Turn student on side to ensure open airway
- Give glucagon as ordered. Keep student in recovery position on side.
- If on insulin pump, either place it in 'suspend' or stop mode, disconnect it at the pigtail or clip, or cut tubing. If pump was removed, send it with EMS to the hospital.
- Notify school nurse, parent and HCP
- Wait 15 minutes; if no response, repeat glucagon.
 - If responsive, offer juice. Wait 15 minutes and give protein & carbohydrate snack.

15 GM FAST-ACTING CARBOHYDRATE =

- ½ c. juice
- 3-4 glucose tablets
- Tube of glucose **gel**
- ½ c. regular (not diet) soda
- 6-7 small sugar candies (to chew)
- 1 c. skim milk

Do not give chocolate

EXERCISE AND SPORTS

- ✓ Assure has quick access to water for hydration, fast-acting carbohydrates, snacks and monitoring equipment.
- ✓ Student should not exercise if blood glucose level is below 70 mg/dl or if has moderate to large ketones.

Never send a child with suspected low blood glucose anywhere alone.

INDIVIDUALIZED HEALTHCARE PLAN - DIABETES

SCHOOL AND PARENT PART

STUDENT'S NAME:				PLAN EFFECTIVE DATE:		Student's photo	
<i>Diabetes information</i> Date of Diagnosis: _____ <input type="checkbox"/> Diabetes Type 1 <input type="checkbox"/> Diabetes Type 2 <input type="checkbox"/> Other							
SCHOOL INFORMATION							
<i>Grade:</i> _____		<i>Teacher:</i> _____		<i>504 plan on file:</i> <input type="checkbox"/> Yes <input type="checkbox"/> No			
CONTACT INFORMATION:							
Parent/Guardian 1:		Name _____ Call first <input type="checkbox"/>					
Phone numbers:		Home _____		Work _____		Cell _____ Other _____	
Parent/Guardian 2:		Name _____ Call first <input type="checkbox"/>					
Phone numbers:		Home _____		Work _____		Cell _____ Other _____	
Other/emergency:		Name: _____			Relationship: _____		
Phone numbers:		Home _____		Work _____		Cell _____ Other _____	
Additional Times to Contact Parent...				Student treated by pump :			
Student treated by injection <input type="checkbox"/> Blood Glucose test out of target range <input type="checkbox"/> Routine Daily Insulin injections <input type="checkbox"/> Correction dose				<input type="checkbox"/> Blood Glucose test out of target range <input type="checkbox"/> Carbohydrate bolus <input type="checkbox"/> Correction bolus <input type="checkbox"/> Infusion set comes out/needs to be replaced			
STUDENT DIABETES SELF-MANAGEMENT PLAN							
Student will manage diabetes independently <input type="checkbox"/> Student has signed Agreement for Student Independently Managing Diabetes		Trained staff will supervise student self-care <input type="checkbox"/> Verify blood glucose test <input type="checkbox"/> Check carbohydrate count <input type="checkbox"/> Confirm dose <input type="checkbox"/> Supervise insulin self-injection <input type="checkbox"/> Monitor bolus administration <input type="checkbox"/> Trouble shoot pump alarms, malfunction <input type="checkbox"/> Watch infusion set change			Trained staff will provide care <input type="checkbox"/> Test blood glucose <input type="checkbox"/> Count carbohydrates <input type="checkbox"/> Calculate insulin dose and inject as above <input type="checkbox"/> Provide insulin injection <input type="checkbox"/> Administer bolus <input type="checkbox"/> Trouble shoot pump alarms, malfunction <input type="checkbox"/> Change infusion set		
Comment: _____							
FOOD PLAN		Time		Notes		Monitor/Remind Student	
						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Breakfast							
Morning snack							
Lunch							
Afternoon snack							
Extra snack Before exercise							
After exercise							
FOOD at a classroom/school party:							
<input type="checkbox"/> Student will eat treat <input type="checkbox"/> Replace the treat with a parent-supplied alternative <input type="checkbox"/> Put in baggie to take home with teacher note <input type="checkbox"/> Student should not eat treat <input type="checkbox"/> Modify the treat as follows: _____							
BUS TRANSPORTATION PLAN							
Bus transportation: <input type="checkbox"/> To school <input type="checkbox"/> Home							
<input type="checkbox"/> Test blood 10-20 minutes before boarding school bus home. Student must have blood glucose > 70 mg/dl to board bus ; if ≤ 70, provide care based on algorithm and call to have student picked up. <input type="checkbox"/> Blood test not required.						<input type="checkbox"/> Student may test blood glucose and self-manage diabetes while on the bus.	
FIELD TRIPS							
<input checked="" type="checkbox"/> School nurse to be notified two weeks before the field trip to assure qualified personnel are available. <input type="checkbox"/> All diabetes supplies are taken and care is provided according to this Plan (copy to accompany trip). <input type="checkbox"/> Lunch and snack times should not change.							
SCHEDULED AFTER- OR BEFORE-SCHOOL ACTIVITIES							
List of clubs, sports, etc. that student anticipates: _____							
If parent wants trained staff coverage for an activity, parent will notify school nurse two weeks before it begins							

STUDENT'S NAME:					PLAN EFFECTIVE DATE:						
<input checked="" type="checkbox"/> Means student uses this item AND parent will provide.											
SUPPLY LIST	<input type="checkbox"/> Blood Glucose Test Kit										
	<input type="checkbox"/> Meter <input type="checkbox"/> Test strips <input type="checkbox"/> Lancing device and lancet		<input type="checkbox"/> Sharps container <input type="checkbox"/> Anti-bacterial cleaner/alcohol swabs		<input type="checkbox"/> cotton balls <input type="checkbox"/> spot band-aids		Glucose meter brand/model:				
	<input type="checkbox"/> Insulin										
	<u>Treatment by Injection</u> <input type="checkbox"/> Insulin pen <input type="checkbox"/> Pre-filled syringes (labeled per dose) <input type="checkbox"/> Insulin vials and syringes			<u>Treatment by Pump</u> <input type="checkbox"/> Pump syringe <input type="checkbox"/> Pump tubing/needle <input type="checkbox"/> Batteries <input type="checkbox"/> Tape			<input type="checkbox"/> Sof-serter <input type="checkbox"/> Insulin vial and syringes		Infusion set type: _____		
	Pump type <input type="checkbox"/> Medtronic MiniMed www.minimed.com (800) 826-2099										
	<input type="checkbox"/> Animas www.animas.com (877) 767-7373			<input type="checkbox"/> Omnipod www.myomnipod.com (800) 591-3455							
	<input type="checkbox"/> Low Blood Glucose (5-day supply) <input type="checkbox"/> Fast-acting carbohydrate drink (apple juice, orange juice, regular soda pop – NOT diet), ≥ 6 containers <input type="checkbox"/> Pre-packaged snacks (e.g., crackers with cheese or peanut butter, nite bite), ≥ 5 servings <input type="checkbox"/> Supply of fast-acting glucose at least equal to 15 gm per day for 5 days (e.g., ≥ 75 gm total)										
	<input type="checkbox"/> Glucagon Kit										
	<input type="checkbox"/> High Blood Glucose <input type="checkbox"/> Urine ketone test strips/bottle <input type="checkbox"/> Urine cup <input type="checkbox"/> Water bottle (Timing device may be wall clock or watch)										
	<input type="checkbox"/> 3-day Disaster Kit <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <input type="checkbox"/> Complete daily insulin dose schedule (separate page) <input type="checkbox"/> Blood glucose test kit (testing strips, lancing device, lancets, meter batteries) <input type="checkbox"/> Vial of insulin and 6 syringes; insulin pens and supplies <input type="checkbox"/> Insulin pump and pump supplies <input type="checkbox"/> Hypoglycemia treatment supplies, ≥ 3 episodes </div> <div style="width: 35%;"> <input type="checkbox"/> Other medications, including glucagon kit <input type="checkbox"/> Urine ketone strips/plastic cup <input type="checkbox"/> Antiseptic wipes or hand sanitizer <input type="checkbox"/> 3-day food supply with meal plan <input type="checkbox"/> Other: </div> </div>										
<input type="checkbox"/> Other											
SUPPLY LOCATIONS		With student	In classroom	In health office	Other		With student	In classroom	In health office	Other	
	Daily breakfast, snacks and lunch					Blood glucose test kit Extra kit					
	Extra snacks					Pump supplies					
	Low blood glucose supplies					Insulin Daily use Extra/emergency					
	High blood glucose supplies					Disaster Disaster food					
	Other										
SIGNATURES As parent/guardian of the above-named student, I give permission for the school nurse and/or other trained staff of _____ (school) to perform and carry out the diabetes care tasks as outlined in this Individualized Healthcare Plan.											
<ul style="list-style-type: none"> ○ I have reviewed this plan and agree with the indicated instructions. I understand that the school is not responsible for equipment loss or damage, or expenses associated with these treatments and procedures. ○ I understand that the information contained in this plan will be shared with other school staff on a need-to-know basis. ○ I give permission to the school nurse to contact my child's physician/health care provider and discuss my child's care related to this plan. ○ I will notify the school nurse whenever there is any change in my child's health status or care. ○ My child and I are responsible for maintaining the necessary supplies, snacks, blood glucose meter, medications and other equipment. 											
Student's parent/guardian _____				Date _____		Student's parent/guardian _____				Date _____	
School nurse _____ Date _____											

INDIVIDUALIZED HEALTHCARE PLAN - DIABETES

SCHOOL NURSE AND PARENT-AUTHORIZED TRAINED STAFF COVERAGE **WORKSHEET**

School nurse will be on-site

	Mon	Tue	Wed	Thurs	Fri
First period					
Second period					
Third period					
Fourth period					
Fifth period					
Sixth period					
Seventh period					
Field Trip					
Before school starting __ AM					
After school ending __ PM					
Other					

Notes/comments:

Schedule for Parent-Authorized Trained Staff

Staff person's Name	Day(s) responsible	Time(s) responsible	Contact phone
	<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F	From: To: or Period:	
	<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F	From: To: or Period:	
	<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F	From: To: or Period:	
	<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F	From: To: or Period:	
	<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F	From: To: or Period:	
	<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F	From: To: or Period:	
	<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F	Before school starting ____AM	
	<input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F	After school ending ____PM	
	Field trip		
	Other		
	Other		

Attach if needed

- ☐ Delegation training completion
- ☐ Parent delegation authorization
- ☐ more..

AGREEMENT FOR STUDENTS INDEPENDENTLY MANAGING THEIR DIABETES

Student: _____

Grade: _____

Student

- ☐ I agree to dispose of any sharps either by keeping them in my kit and taking them home, or placing them in the sharps container provided at school.
- ☐ I will notify the health office if my blood sugar is below _____ mg/dl or above _____ mg/dl.
- ☐ I will not allow any other person to use my diabetes supplies.
- ☐ I plan to keep my diabetes supplies:
 - ☐ With me
 - ☐ In the school health office
 - ☐ In an accessible and secure location (_____)
- ☐ I will seek help in managing my diabetes from _____ if I need it.
- ☐ I understand that the freedom to manage my diabetes independently is a privilege and I agree to abide by this contract.

Student's signature: _____ Date: _____

Parent/Guardian

- ☐ I agree that my child can self-manage his/her diabetes and can recognize when he/she needs to seek help from a staff member.
- ☐ I will provide back-up supplies to the health office for emergencies.
- ☐ I understand that this contract is in effect for the current school year unless revoked by my son/daughter's physician or my son/daughter fails to meet the above safety guidelines.

Parent's signature: _____ Date: _____

School nurse

- ☐ I will assure that school staff members that need to know about this student's condition and that he/she must to carry their diabetes supplies with them have been notified.

School Nurse's signature: _____ Date: _____

ALASKA INDIVIDUALIZED HEALTHCARE PLAN – DIABETES WITH INJECTION OR WITH PUMP

Instructions

Purposes:

This healthcare plan is for all students with diabetes that monitor blood glucose at school and/or are on insulin or other hypoglycemic medication and/or have a glucagon prescription.

1. Healthcare providers should use it to prescribe a particular treatment regimen including medication(s) for school (HEALTHCARE PROVIDER ORDERS pages)
 - a. It documents the ability level of the student to self-manage their diabetes.
 - b. It provides the medical parameters for management of an individual student's diabetes in the school setting.
2. It describes the standard of care for school staff to follow based on blood glucose test results and is the *Emergency Care Plan* for students with diabetes. (ALGORITHMS FOR BLOOD GLUCOSE RESULTS page)
3. School nurses and parents should use it to plan and implement individualized health interventions in the school setting, based on the Healthcare Provider Orders page. (SCHOOL AND PARENT PART pages)
 - a. To support quality assurance of school health services.
 - b. To document parental wishes for diabetes management-related contact by school staff.
 - c. To document diabetes supplies needed at school, their locations and parental responsibility for maintaining certain supplies at school.
 - d. To facilitate a safe process for the delegation of diabetes-management tasks to trained unlicensed school staff, as needed.
4. School nurses and parents *may* use it to identify times when the school nurse will not be available to provide diabetes management assistance and plan for coverage by trained school staff. (SCHOOL NURSE AND PARENT-AUTHORIZED TRAINED STAFF COVERAGE WORKSHEET)

While current, this form should be kept in the school health office or with the staff member who is assisting with the health management of the student.

Process:

1. Healthcare provider completes either the WITH INJECTION or the WITH PUMP page of the form to describe anticipated medications/treatment needs for the entire school year, and sends it to the school nurse (if known) and/or the student's parent to bring into the school.
 - a. If medications and/or treatment change during the school year, a new form should be completed. Fax only the page with new orders to the school.
 - b. Most categories are self-explanatory. On either form, check all boxes that apply and add information as appropriate.

DIABETES WITH INJECTION notes:

- In the *Routine Daily Insulin Injection* box, there are three options for Type. NPH and Lantis are examples of "other." The relevant doses/times for these injections would be listed in the "Standard daily insulin injection" table.
- Instructions in the *Correction insulin dose for high blood glucose* box are for a routine day as correction dosing is generally given at mealtime, which means that:
 - Action directed by the algorithm page supersedes "before lunch only" when it is checked because it is based on the student's symptoms and blood glucose levels.
 - The "Do not give insulin correction dosing more often than every 2 to 3 hours" statement applies to symptomatic treatment based on blood glucose levels in most instances.

- In the *Parent/Guardian Authority to Adjust Insulin Dose* box, parental authority to adjust the dose by 10-20% allows the parent to recommend a dose adjustment to the nurse which the nurse could follow without contacting the health care provider **if that dose is within the range % allowed**. If the dose recommended by the parent falls outside of the range, either smaller or larger, the nurse would need to contact the health care provider to verify the dose.
- c. Healthcare provider signs and dates the WITH INJECTION or WITH PUMP page and faxes or sends the orders to the school.
- 2. While meeting with the school nurse, the parent uses the boxes at the top of the ALGORITHMS page to indicate which of the symptoms of low and high blood sugar generally occur for their child.
- 3. Together, the school nurse, parent and the student, if student is self-managing his/her diabetes, complete the SCHOOL AND PARENT PART of the form.
 - a. Most categories are self-explanatory. Check all boxes that apply and add information as appropriate.
 - In the *Student Diabetes Self-Management Plan* box:
 - The repeated skills list (from the healthcare provider section) allows parent input and school nurse assessment of the student skill level and the level of supervision or assistance needed. If the student skill level increases during the school year, this section allows the school nurse and parent to adjust the self-management plan accordingly.
 - “Trained staff” (right-side column) in this instance includes the school nurse.
 - For “Change infusion set” under “Trained staff will provide care”, the school nurse is typically **the only** trained staff changing the infusion set for a student on a pump. Add this comment when needed.
 - The SUPPLY LIST is intended to promote best practice. Generally, it should be interpreted by the nurse and the parent as a guide.
 - If the parent is unable to provide urine ketone test strips, contact the American Diabetes Association (907 272-1424).
 - b. Parents and School Nurse sign and date the SCHOOL AND PARENT PART. If student will be self-managing, student signs the STUDENT SELF-MANAGEMENT AGREEMENT.
 - c. Update as needed and/or on a yearly basis.
- 4. The school nurse may use the WORKSHEET page to identify times when he/she will regularly be unavailable to assist the student with diabetes management and plan for coverage by trained school staff.
- 5. File the entire document with student’s health record at the end of the year or upon student withdrawal.